Bill C-203: a postmortem analysis of the "right-to-die" legislation that died

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Résumé : Le projet de loi C-203 était censé être une solution législative à l'éventuelle responsabilité criminelle des médecins quant au respect de la volonté des patients de renoncer (retenue ou retrait) à un traitement de maintien de la vie ou à la prestation de soins palliatifs appropriés. Les auteurs examinent les causes de la mort au Feuilleton du project de loi : son incapacité de poser clairement un problème, la pertinence de la solution, les répercussions de celle-ci (c'est-à-dire aboutirait-elle à l'euthanasie) et les questions de procédure inhérentes au rejet du project de loi. Des recommandations sont données pour les futures initiatives législatives et de politique publique sur les soins en fin de vie.

On May 16, 1991, Mr. Robert Wenman, member of Parliament for Fraser Valley West (British Columbia), introduced Bill C-203 (an Act to amend the Criminal Code [terminally ill persons]) (Appendix 1) in the House of Commons. The purpose of the bill was as follows.

> To protect a physician from criminal liability where the physician does not initiate or continue treatment at the request of the patient or where the physician does not prolong life, except at the patient's request. It would also protect a physician who administers pain killing treatment to a patient even though the effect of that treatment will hasten death.[1]

Bill C-203 passed a second reading on Sept. 24, 1991, and was referred to a legislative committee. The committee began interviewing witnesses on Oct. 29, 1991. On Feb. 18, 1992, after testimony was heard from 25 witnesses, the proceedings were adjourned. Because this decision was reached *in camera* the reasons behind it were not made public. However, the views of several witnesses have been published (*Globe and Mail*, Toronto, Feb. 27, 1992: A21).[2-4] No date has been set for the resumption of hearings, and it is unlikely that Parliament will consider the issue again unless the bill or something like it is tabled by the federal government.

We examined the records of the committee hearings[5] to document the arguments presented to the legislative committee and several aspects of the federal legislative process that may have influenced the bill's fate. Our goal was to uncover lessons from Bill C-203 to make recommendations on legislative and public policy initiatives about end-of-life care.

Substantive arguments

Bill C-203 was meant to be a legislative solution to a legal problem — the potential criminal liability of physicians in respecting patients' wishes to forgo

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(withhold or withdraw) life-sustaining treatment or in providing appropriate palliative care. The solution was to amend the Criminal Code to eliminate such liability. Three categories of issues are involved in the assessment of Bill C-203: the clear establishment of a problem, the adequacy of the proposed solution and the acceptibility of the implications of the solution.

The problem

Of the 25 witnesses who testified at the hearings 11 denied that a serious problem existed to warrant the amendment on forgoing treatment: no physician in Canada had ever been criminally prosecuted or formally charged for forgoing treatment at a patient's request, and the right of patients to forgo treatment was already guaranteed under common law.

These arguments are flawed for four reasons. First, the problem is not that charges *have* been laid but that they *could* be, as stated by Wenman several times during the hearings. Second, that charges could be but have not yet been laid is further cause for concern. Physicians are left feeling uncertain about how the courts might behave in such a situation. Third, the bill was meant to solve not the right of patients to forgo treatment but, rather, the ability of physicians to honour that right without being at risk for criminal prosecution. Finally, the inconsistency or contradiction in the law places physicians in an untenable position: if they do not follow their patients' wishes to forgo life-sustaining treatment they could face common or civil law charges of assault, and if they follow their patients' wishes they could face criminal charges of murder or manslaughter.

There was less dissent on the need for the amendment on palliative care. Of the 11 witnesses who denied the need for the amendment on forgoing treatment 4 conceded the need for the one on palliative care. Only one witness claimed that the palliative care amendment did not address a genuine problem and argued that it was a misunderstanding to associate palliative care with procedures that might hasten death.

Despite Wenman's repeatedly insisting that the bill was not designed to address euthanasia 12 witnesses focused on this issue, some even insisting that it was explicitly a euthanasia bill. Some witnesses attempted to sort out the semantic and conceptual intricacies of the euthanasia issue, differentiating it from the bill's proposals. However, on the whole there was no consistency in the definitions during the hearings. The committee never asked the participants to define their terms, nor did it stipulate operative definitions or try to ensure clarity and consistency in terms. (For instance, euthanasia can be defined as "the deliberate action by a physician to terminate the life of a patient,"[6] the clearest example being the act of giving a lethal injection of potassium chloride.) As a result, at least half of the discussion was on euthanasia.

Adequacy of the solution

All except one of the witnesses argued that Bill C-203 had at least one or two serious flaws. In some cases the suggested revisions were extensive.

One source of concern for most of the witnesses was the phrase "medically useless." Many also pointed out that the phrase "terminally ill [person]" occurred only in the title of the bill and not in its content, which raised the question of the bill's intended scope. Several witnesses requested a clearer definition of "treatment" and wondered if it included artificial nutrition and hydration.

Probably the biggest complaint was about the phrase "clearly requests," used when a person is said to "clearly request" that treatment be either ceased or not initiated. Some witnesses were concerned that this phrase, which represented competency, was undefined and that the procedures to determine competency were not stipulated. Others were concerned that the phrase might preclude the use of advance directives (living wills) in decision making for incompetent patients.

Because the committee hearings were adjourned it is unknown whether and to what extent the legislative committee process would have remedied the flaws.

Implications of the solution

Eleven witnesses rejected Bill C-203 because they believed that it would promote euthanasia. (One argued that there is a "slippery slope" leading from the bill to euthanasia.) The "evidence" cited for this conclusion was from Holland, where euthanasia is practised, and from atrocities in Nazi Germany. Unfortunately, the evidence from Holland was not objectively documented at the hearings, even though the committee felt it should have been.[7] Some witnesses were concerned that at a time of fiscal restraint and with a growing population of elderly people the provisions contained in Bill C-203 might be abused.

Several witnesses argued that the language of sections 217.1 (c) and 246.1 (b) was ambiguous (Appendix 1), particularly the phrase in section 217.1 (c) "for the sole reason that such care or measures will or are likely to shorten the life expectancy of the person." They felt that rather than permitting proper pain control that might lead to the shortening of life this phrase might permit procedures whose sole

reason was to end life — that is, euthanasia. Several witnesses suggested that the bill could be amended to clarify that its intent and substance did not include euthanasia.

Process issues

Any private member's bill is unlikely to become law, especially without significant support from a majority government. Then Minister of Justice Kim Campbell was reportedly sympathetic to Bill C-203 (*Ottawa Sun*, Mar. 28, 1991: 22); however, the testimony given by members of her department tells a different story. The Department of Justice refused to comment on the content of the bill, concentrating instead on the argument that more consultation was required before the bill could proceed. Moreover, it was felt that the bill was stopped by "three Liberal members [of the committee] who seem to see no separation between church and state" and a Conservative member of Parliament who was not a committee member but "was parachuted in to join the Liberals' 'God Squad' " (*Globe and Mail*, Feb. 27, 1992: A21).

As well, the CMA declined to testify at the hearings. On Nov. 28, 1991, a letter explaining the CMA's decision not to testify was read to the committee. It stated the following.

> The issues addressed by the Bill are currently the subject of intensive review by the CMA's Committee on Ethics and a Joint Committee comprised of the CMA, the Canadian Nurses Association, and the Canadian Hospital Association. We believe that to appear before your Committee at a time when our own review of the issues is not yet complete would be to do both your Committee and our members a disservice.[8]

The refusal of the CMA to testify undoubtedly had a negative impact on the chances of the bill's becoming law. The committee members placed such importance on the CMA's testimony that they considered subpoenaing the CMA. The failure of the CMA to testify prompted one committee member to state "Doctors aren't concerned about this bill — Why should we [be]?" (*Globe and Mail*, Feb. 27, 1992: A21).

Finally, given that health care falls largely under provincial jurisdiction, broader consultation with provincial governments should have occurred. For example, Manitoba recently passed legislation on advance directives,[9] and Ontario recently passed legislation on consent to treatment.[10-13]

Recommendations

Bill C-203 is dead. However, our postmortem analysis suggests several recommendations for future legislative and public policy initiatives on end-of-life care.

First, since the two amendments in Bill C-203 were logically distinct, two independent pieces of legislation could be submitted. In fact, the amendment on palliative care received far more support than the one on forgoing treatment. Tabling the two amendments separately would not tie the success of one to the other.

Second, any future legislative policy initiatives should have agreement on terminology, particularly "forgoing treatment," "palliative care" and "euthanasia."

Third, future initiatives should avoid, or at least use with greater precision, the concept of medical uselessness; there is much published literature that could aid the understanding of this.[14-20] Moreover, the scope of future initiatives (whether they apply to terminally ill people only or to all people) and the definition of treatment (whether it includes artificial nutrition and hydration) should be clearly stipulated.

Fourth, advance directives and competency should be addressed. Even though these issues are primarily under provincial jurisdiction a legislative or policy initiative on end-of-life care would be incomplete if it did not address them.

Fifth, the CMA should be more active in initiatives on end-of-life care. As health care professionals, physicians should participate constructively in democratic political processes that focus on health care issues of pressing national importance.

On Mar. 25, 1992, a subcommittee of the Standing Committee on Justice and the Solicitor General was struck to study proposals for a new "general part" of the Criminal Code.[21] If and when Parliament begins to consider the specific sections of the Criminal Code related to end-of-life care the lessons from Bill C-203 should be helpful.

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Appendix 1: Bill C-203 (an Act to amend the Criminal Code [terminally ill persons])

1. The Criminal Code is amended by adding, immediately after section 217 thereof, the following:

217.1 Nothing in sections 14, 45, 216 and 217 of the Criminal Code shall be interpreted as

(a) requiring a qualified medical practitioner to commence or continue to administer surgical or medical treatment to a person who clearly requests that such treatment not be commenced or continued,

(b) requiring a qualified medical practitioner to commence or continue to administer surgical or medical treatment to a person where such treatment is medically useless and not in the best interests of the person, except where the person clearly requests that such treatment be commenced or continued; or

(c) preventing a qualified medical practitioner from commencing or continuing to administer palliative care and measures intended to eliminate or relieve the physical suffering of a person for the sole reason that such care or measures will or are likely to shorten the life expectancy of the person.

2. The said Act is further amended by adding, immediately after section 246 thereof, the following:

246.1 Notwithstanding anything in sections 215 and 218 to 246, no qualified medical practitioner commits any offence set out in those sections where the practitioner

(a) does not commence or continue to administer

(i) surgical or medical treatment to a person who clearly requests that such treatment not be commenced or continued,

(ii) surgical or medical treatment to a person where such treatment is medically useless and not in the best interests of the person, except where the person clearly requests that such treatment be commenced or continued; or

(b) commences or continues to administer palliative care or measures intended to eliminate or to relieve the physical suffering of a person where such care or measures will or are likely to shorten the life expectancy of the person.

246.2 For the purposes of sections 217.1 and 246.1, "qualified medical practitioner" means a person who is entitled to practice medicine under the laws of a province and includes any person working under the direction of that person.

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